

[Your Name]
[Your Address]
[Your City, State, Zip Code]
[Your Phone Number]
[Your Email]

[Date]

[Billing Department Name]
[Medical Facility/Provider Name]
[Address]
[City, State, Zip Code]

RE: Final Balance Verification and Account Closure

Account Number: [Your Account Number]
Patient Name: [Patient Name]
Date of Service: [Date of Service]

To Whom It May Concern,

I am writing to formally request a final verification of the balance on the above-referenced account. According to my records, a final payment in the amount of \$[Amount Paid] was made on [Date of Payment].

Please provide a written statement or a "Zero Balance" letter confirming that this account is paid in full and that no further charges are outstanding. This documentation is required for my personal records and to ensure there are no future discrepancies regarding this debt.

If your records show a remaining balance, please provide an itemized statement detailing all charges, insurance adjustments, and payments applied to the account to date.

Please send this confirmation to my address listed above within [Number of Days, e.g., 15] business days. Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]